

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

68-089617

STATE FILE NUMBER

Registration District No. 122 Primary Registration District No. 2000 Registrar's No. 1557

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED NOV 13 1963

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Rogersville</b>	
Length of stay in 1b <b>1 Day</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Baptist Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Rt. # 2</b>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>MAY</b> Last <b>STAIGE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-2-1881</b>
9. AGE (last birthday) <b>81</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <b>Porterville, Calif.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Augustus Straeger</b>		13b. MOTHER'S MAIDEN NAME <b>Dunn</b>	
14. NAME OF HUSBAND OR WIFE <b>Mrs. Ellen Bailey Rogersville, Mo.</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ellen Bailey Rogersville, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>mesenteric artery thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>arteriosclerosis</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>4 AM</b> Month, Day, Year <b>11/10/63</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Springfield Mo.</b>	
20g. COUNTY		20h. STATE	
21. I attended the deceased from <b>1961</b> to <b>death</b> and last saw her alive on <b>11/9/63</b> Death occurred at <b>4 AM</b> on <b>11/10/63</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Leo T. Neuf MD</b>	
22b. ADDRESS <b>Springfield Mo.</b>		22c. DATE SIGNED <b>9/13/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>	23b. DATE <b>11-16-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Whittier, California</b>
24. FUNERAL DIRECTOR <b>Kelley-Ferrell</b>	25. DATE RECD. BY LOCAL REG. <b>11-12-63</b>	26. REGISTRAR'S SIGNATURE <b>Leo T. Neuf</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Wm. K. Ferrell

Licensed Embalmer No. 4910

P. O. Address Rogersville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

11/12/63